

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Pharmacies
All Prescribers
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No.: 03-61 MAA
Issued: August 21, 2003

For More Information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: Updates to the Prescription Drug Program

Effective for claims with dates of service on and after October 1, 2003 (unless otherwise specified within this numbered memoranda), the Medical Assistance Administration (MAA) will implement the following updates to the Prescription Drug Program:

- Additions to the Preferred Drug List;
- Additions and modifications to Expedited Prior Authorization Codes and Criteria;
- Changes in Limitations of Certain Drugs; and
- Removal from and changes to Prior Authorization requirement of certain drugs.

MAA's Preferred Drug List

Non-preferred drugs in these classes will require the pharmacy to call MAA for prior authorization.

| Drug Class | Preferred Drug |
|--|---|
| Angiotensin-Converting Enzyme (ACE) Inhibitors | captopril, enalapril, lisinopril (ramipril is available using EPA criteria) |
| Triptans | rizatriptan (except orally disintegrating tablets) and sumatriptan |

Additions to MAA's Preferred Drug List in TCS

Non-preferred drugs in these classes will trigger a TCS review

| Drug Class | Preferred Drug |
|-------------------------------|---|
| Proton Pump Inhibitors (PPIs) | esomeprazole, lansoprazole, pantoprazole, rabeprazole |

Replacement page F.1/F.2 is attached for MAA's Prescription Drug Program Billing Instructions, dated February 2003 reflecting the change above.

Additions and Modifications of Expedited Prior Authorization Codes and Criteria

| Drug | Code | Criteria |
|---|------|---|
| Effective for the week of October 6, 2003 and after | | |
| Zometa® (Zoledronic acid) | 011 | Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors. |
| Risperdal® (Risperidone) Zyprexa® Zyprexa Zydis® (Olanzapine) | 054 | All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is 6 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above. (dementia indication deleted) |
| Ambien® (Zolpidem tartrate) Sonata® (Zaleplon) | 006 | Short-term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can be continued. |
| Altace® (Ramipril) | 020 | Patients with a history of cardiovascular disease. |

| Drug | Code | Criteria |
|--|----------------|---|
| Effective for the week of October 6, 2003 and after | | |
| Bextra® (Valdecoxib) | 078 079 | <p>Before any code is allowed, the patient must:</p> <ul style="list-style-type: none"> a) Have an absence of a history of ulcer or gastrointestinal bleeding; b) Have tried and failed or is intolerant to at least two generic NSAIDs; c) Be 18 years of age or older; d) Have an absence of sulfa allergy; and e) Have an absence of history of rash while on Bextra. <p>Diagnosis of osteoarthritis or rheumatoid arthritis in patients 18 years of age or older. Dose limited to 10mg per day.</p> <p>Treatment of primary dysmenorrhea in patients 18 years of age or older. Dose limited to 20mg two times per day.</p> |
| Rebif® (Interferon beta 1-A) | 119 | Prescribed by, or in consultation with a neurologist, for the treatment of relapsing multiple sclerosis (MS). |

Limitations of Certain Drugs

| Drug | Limit |
|--------------------------------|-----------------------|
| Ambien® (Zolpidem tartrate) | 10 in a 30-day period |
| Sonata® (Zaleplon) | 10 in a 30-day period |

To view MAA's current list of Limitations of Certain Drugs,
go to:
<http://maa.dshs.wa.gov/pharmacy>

Drugs Removed from MAA's Prior Authorization List

| Drug |
|--|
| Elidel® for age 5 and under (<i>Pimecrolimus</i>) |
| Protopic® for age 5 and under (<i>Tacrolimus</i>) |
| Tretinoin for age 25 and under |
| Synagis® for age 1 year and under during RSV season only (<i>Palivizumab</i>) |

Drugs Added to MAA's Prior Authorization List

| Drug |
|--|
| ACE-inhibitors; All brands except Altace® (see EPA criteria for Altace®) |
| Triptans; Axert®, Relpax®, Frova®, Amerge®, Maxalt MLT®, Zomig®, Zomig - ZMT® |

Replacement Pages

Attached is Section H of MAA's Prescription Drug Program Billing Instructions, dated February 2003 reflecting the changes in this memorandum to the Expedited Prior Authorization List.

Therapeutic Consultation Service (TCS)

[Refer to WAC 388-530-1260]

Overview of TCS

MAA provides a complete drug profile review for each client when a drug claim for that client triggers a TCS consultation. The purpose of TCS is to facilitate the appropriate and cost-effective use of prescription drugs. MAA-designated clinical pharmacists review profiles in consultation with the prescriber or the prescriber's designee by telephone.

TCS occurs when a drug claim:

- Exceeds four brand name prescriptions per calendar month; or
- Is for a nonpreferred drug within MAA's selected therapeutic classes (see MAA's Preferred Drug List on page F.2). **This does not apply to the Voluntary Preferred Drug List.**

When a pharmacy provider submits a claim that exceeds the TCS limitations for a client, MAA generates a Point-of-Sale (POS) computer alert to notify the pharmacy provider that a TCS review is required. The computer alert provides a toll-free telephone number (866) 246-8504 to the pharmacy for the prescriber or prescriber's designee to call.

Drugs excluded from the four brand name prescription per calendar month review

Drugs excluded from the four brand name prescription per calendar month review:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Chemotherapy drugs
- Contraceptives
- HIV medications
- Immunosuppressants
- Hypoglycemia rescue agents
- Generic drugs

Preferred Drug List

MAA chooses a drug or drugs from a selected therapeutic class for placement on the preferred list when:

- There is evidence that one drug has superior safety, efficacy, and effectiveness compared to others in the same drug class; or
- The drugs in the class are essentially equal in terms of safety and efficacy; and
- The selected drug or drugs may be the least costly in the therapeutic class.

Preferred Drug List

| Selected Therapeutic Drug Class | Preferred Drug(s) |
|---|---|
| Histamine H2 Receptor Antagonist (H2RA) | Ranitidine |
| Proton Pump Inhibitors (PPIs) | esomeprazole, lansoprazole, pantoprazole, rabeprazole |
| Non-sedating antihistamines | Over-the-counter (OTC) Loratadine |

Voluntary Preferred Drug List

The following drug classes are voluntary preferred drugs that will be suggested to prescribers during TCS consultation. Non-preferred drugs in these drug classes will not trigger a review unless the request is the fifth request for a brand name drug in a calendar month.

| Selected Therapeutic Drug Class | Preferred Drug(s) |
|---|--|
| Statin-type cholesterol-lowering agents | <p>LDL lowering $\leq 30\%$ = generic lovastatin</p> <p>LDL lowering $\geq 31\%$ through 40% = Zocor® (first choice) or Lipitor® (second choice)</p> <p>LDL lowering $\geq 41\%$ = Lipitor®.</p> <p>Pravachol® may be used when drug-drug interactions with concurrent drug therapy are likely (gemfibrozil, protease inhibitors)</p> |

| Drug | Code | Criteria |
|------------------------------------|------|---|
| Abilify® (Aripiprazole) | 015 | All of the following must apply: <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is 18 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above. |
| | | |
| | | |
| Accutane® (Isotretinoin) | | Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be absent : <ul style="list-style-type: none"> a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease. |
| | 001 | Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy. |
| | 002 | Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy. |
| | 003 | Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist. |
| | 004 | Prevention of skin cancers in patients with xeroderma pigmentosum. |
| | 005 | Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies. |

| Drug | Code | Criteria |
|---|------|--|
| Actonel® (Risendronate Sodium) | 142 | Treatment of Paget's disease of the bone at doses of 30mg per day for two months. Retreatment may be necessary with same dose duration. |
| | 143 | Prevention of osteoporosis in post-menopausal women at doses of 5mg per day when hormone replacement is contraindicated. |
| | 144 | Treatment of osteoporosis in post-menopausal women at doses of 5mg per day. |
| | 146 | Prevention and treatment of glucocorticoid-induced osteoporosis in men and women at doses of 5mg per day. |
| | 148 | Prevention and treatment of osteoporosis in post-menopausal women at doses of 35mg per week. |
| Adderall® (Amphetamine/ Dextroamphetamine) | 026 | Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: <ul style="list-style-type: none"> a) The prescriber is an authorized schedule II prescriber; and b) Patient is 3 years of age or older. |
| | 027 | Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber. |
| | 087 | Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber. |
| | | |

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Adderall XR® 094
(*Amphetamine/
Dextroamphetamine*)

Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following:

- a) The prescriber is an authorized schedule II prescriber; and
- b) Patient is **6** years of age or older; and
- c) Total daily dose is administered as a single dose.

**Adeks®
Multivitamins** 102

For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all of the following:

- a) Patient is under medical supervision; and
- b) Patient is not taking oral anticoagulants; and
- c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

**Advil®
Suspension** 038
(*Ibuprofen suspension*)

Diagnosis of chronic inflammatory disease or syndrome such as Juvenile Rheumatoid Arthritis (JRA).

073

Diagnosis of chronic pain and all of the following:

- a) Patient is **12** years of age or older; and
- b) Cannot swallow tablets; and
- c) Is intolerant to aspirin drug therapy.

074

Diagnosis of chronic pain or sustained fever and all of the following:

- a) Patient is between six months and **12** years of age; and
- b) The patient has tried and failed acetaminophen elixir.

Aggrenox® 037
(*Aspirin/
Dipyridamole*)

To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following:

- a) The patient has tried and failed aspirin or dipyridamole alone; and
- b) The patient has no sensitivity to aspirin.

Altace® 020
(*Ramipril*)

Patients with a history of cardiovascular disease.

Ambien® 006
(*Zolpidem tartrate*)

Short-term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can be continued.

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Amiodarone 010 Prescribed or recommended by a cardiologist/internist.

Angiotensin Receptor Blockers (ARBs) 092

Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Atacand® (Candesartan cilexetil)
Atacand HCT® (Candesartan cilexetil/HCTZ)
Avalide® (Irbesartan/HCTZ)
Avapro® (Irbesartan)
Benicar® (Olmesartan medoxomil)
Cozaar® (Losartan potassium)
Diovan® (Valsartan)
Diovan HCT® (Valsartan/HCTZ)
Hyzaar® (Losartan potassium/HCTZ)
Micardis® (Telmisartan)
Micardis HCT® (Telmisartan/HCTZ)
Teveten® (Eprosartan mesylate)
Teveten HCT® (Eprosartan mesylate/HCTZ)

Anzemet® 127 Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
(Dolasetron mesylate)

Aredia® 011 Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases.
(Pamidronate disodium)

016 Treatment of Paget's disease of the bone.

Aricept® 022 Treatment of dementia of the Alzheimer's type according to the criteria established by the National Institute of Neurological Disorders and Stroke/Alzheimer's Disease Related Disorders Association (NINDS/ADRDA).
(Donepezil)

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Avonex® 119 Prescribed by, or in consultation with a neurologist, for the treatment of relapsing multiple sclerosis (MS).
(Interferon beta 1-A)

Azelex® 101 Diagnosis of acne vulgaris in patients 12 years of age or older.
(Azelaic acid)

Betapace® 010 Prescribed or recommended by a cardiologist/internist.
(Sotalol)

Betaseron® 012 Prescribed by, or in consultation with a neurologist, and clinically confirmed and/or laboratory/imaging-confirmed diagnosis of relapsing/remitting multiple sclerosis (MS) and patient must be ambulatory.
(Interferon beta 1-B)

Bextra® Before any code is allowed, the patient must:
(Valdecoxib)

- Have an absence of a history of ulcer or gastrointestinal bleeding;
- Have tried and failed or is intolerant to at least two generic NSAIDs;
- Be 18 years of age or older;
- Have an absence of sulfa allergy; and
- Have an absence of history of rash while on Bextra.

078 Diagnosis of osteoarthritis or rheumatoid arthritis and dose is limited to 10 mg per day.

079 Diagnosis of primary dysmenorrhea and dose limited to 20mg two times per day.

Calcimar® 016 Treatment of Paget's disease of the bone.
(Calcitonin-salmon)

017 Treatment or prevention of postmenopausal osteoporosis.

123 Treatment of hypercalcemia.

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

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|--|---|---|
| Calcium w/vitamin D | 126 | Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia. |
| Celebrex® (<i>Celecoxib</i>) | Before any code is allowed, the patient must: | |
| | a) | Have an absence of a history of ulcer or gastrointestinal bleeding; |
| | b) | Have tried and failed or is intolerant to at least two generic NSAIDs; |
| | c) | Be 18 years of age or older; and |
| | d) | Have an absence of sulfa allergy. |
| | 139 | Diagnosis of osteoarthritis and dose is limited to 200mg or less per day. |
| | 140 | Diagnosis of rheumatoid arthritis and dose is limited to 400mg or less per day. |
| | 145 | Diagnosis of colorectal polyps and dose is limited to 400mg or less per day. (Exempt from trial with two generic NSAIDs.) |
| | 147 | Diagnosis of acute pain, including primary dysmenorrhea, and dose is limited to 600mg the first day and a maximum of 400 mg on subsequent days. |
| Children's Advil® (<i>Ibuprofen</i>) | | See criteria for Advil® Suspension. |

| Drug | Code | Criteria |
|------|------|----------|
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|--|-----|--|
| Clonazepam | 099 | Prescribed by, or in consultation with, a health care professional with prescriptive authority for this class of drug for psychiatric disorders meeting DSM IV diagnostic criteria on Axis I or II disorder (exclusive of disorders related to substance abuse and childhood related disorders). |
| | 100 | Prescribed for neurologic disorders including Lennox Gastaut Syndrome, akinetic and myoclonic seizures, and absence seizures which have failed to respond to succinimides or when prescribed for restless leg syndrome. |
| | 120 | Prescribed in consultation with a pain specialist for neuropathic pain. |
| | 121 | Prescribed for withdrawal syndromes for up to 30 days when related to alcohol, benzodiazepine, or barbituate use. |
| Clozapine Clozaril® | 018 | All of the following must apply: <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 17 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above. |
| Compazine® Spansules (<i>Prochlorperazine maleate</i>) | 095 | Treatment of nausea and vomiting due to oncology treatment. Patient must have tried and failed Compazine® tablets or suppositories. |

| Drug | Code | Criteria |
|--|------|---|
| Concerta® (Methylphenidate) | 149 | Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber, and b) Patient is 6 years of age or older. |
| Copaxone® Injection (Glatiramer acetate) | 013 | Prescribed by, or in consultation with a neurologist, and clinically-confirmed and/or laboratory/imaging – confirmed diagnosis of relapsing/remitting multiple sclerosis (MS). |
| Cordarone® (Amiodarone) | 010 | Prescribed or recommended by a cardiologist/internist. |
| Cyanocobalamin Injection (Vit. B-12 Injection) | 075 | For the treatment of vitamin B-12 deficiency (pernicious anemia). |
| Danocrine® (Danazol) | | Before any code is allowed, there must be an absence of all of the following: a) Pregnancy b) Breast feeding c) Undiagnosed genital bleeding d) Porphyria e) Impaired hepatic, renal, or cardiac function |
| | 023 | Diagnosis of laparoscopic-proven endometriosis. |
| | 024 | Diagnosis of fibrocystic breast disease with pain/tenderness/nodularity. |
| | 025 | Diagnosis of hereditary angioedema in males or females. |
| Dexedrine® (D-Amphetamine sulfate) | | See criteria for Adderall®. |
| Dextrostat® (D-Amphetamine sulfate) | | See criteria for Adderall®. |

| Drug | Code | Criteria |
|---|------|---|
| Differin® (Adapalene) | 055 | Treatment of acne vulgaris. |
| Enemeez® (Docusate sodium) | | See criteria for Therevac®. |
| Evista® (Raloxifene Hcl) | 017 | Treatment or prevention of postmenopausal osteoporosis. |
| | 034 | Prevention of postmenopausal osteoporosis when hormone replacement therapy is contraindicated. |
| Exelon® (Rivastigmine tartrate) | | See criteria for Aricept®. |
| Focalin® (Dexmethylphenidate) | | See criteria for Concerta®. |
| Fosamax® (Alendronate sodium) | 016 | Treatment of Paget's disease of the bone. |
| | 017 | Treatment or prevention of postmenopausal osteoporosis. |
| | 106 | Treatment of osteoporosis in males. |
| | 122 | Treatment of steroid-induced osteoporosis. |
| Geodon® (Ziprasidone) | 046 | All of the following must apply: a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is 6 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above. |

| Drug | Code | Criteria |
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***Note:** Because Geodon® prolongs the QT interval (> Seroquel® > Risperdal® > Zyprexa®) it is contraindicated in patients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.

Ibuprofen Suspension See criteria for Advil® Suspension.

INFeD®
(Iron dextran)

028 Diagnosis of iron deficiency and all of the following:

- a) Inability to tolerate any oral form of iron therapy; and
- b) The rate of continuing blood loss exceeds the rate at which iron can be absorbed from oral ferrous sulfate.

029 Diagnosis of iron deficiency and all of the following:

- a) Inability to tolerate any oral form of iron therapy; and
- b) Immediate iron replacement is necessary to avoid blood product transfusions.

Infergen® 134 Treatment of chronic hepatitis C viral (HCV) infection in patients **18** years of age or older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.

Intron A® 030 Diagnosis of hairy cell leukemia in patients **18** years of age or older.

031 Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients **18** years of age or older.

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

032 Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.

033 Diagnosis of chronic hepatitis B in patients **1** year of age or older.

107 Diagnosis of malignant melanoma in patients **18** years of age or older.

109 Treatment of chronic hepatitis C in patients **18** years of age or older.

135 Diagnosis of follicular non-Hodgkin's lymphoma in patients **18** years of age or older.

Klonopin®
(Clonazepam) See criteria for Clonazepam.

Kytril® 127 Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.

128 Prevention of nausea or vomiting associated with total body or abdominal radiotherapy.

Marinol® 035 Diagnosis of cachexia associated with AIDS.

036 Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.

Metadate CD® See criteria for Concerta®.

Miacalcin®
(Calcitonin-salmon)
Miacalcin Nasal Spray®
(Calcitonin-salmon) See criteria for Calcimar®.

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Miralax® 021 Treatment of occasional constipation. Must have tried and failed a less costly alternative.
(Polyethylene glycol 3350)

Motrin® Suspension See criteria for Advil®
(Ibuprofen suspension)

Naltrexone See criteria for ReVia®.

Nembutal® Sodium See criteria for Seconal Sodium®.
(Pentobarbital sodium)

Nephrocaps® 096 Treatment of patients with renal disease.

Nephro-FER®
(Ferrous Fumarate/
Folic acid)

Nephro-Vite®
(Vitamin B Comp W-C)

Nephro-Vite RX®
(Folic acid/Vitamin B
Comp W-C)

Nephro-Vite +FE®
(Fe fumarate/FA/
Vitamin B Comp W-C)

Nephron FA®
(Fe fumarate/Doss/
FA/B Comp & C)

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) 141 An absence of a history of ulcer or gastrointestinal bleeding.

Ansaid® (Flurbiprofen)
Arthrotec® (Diclofenac/misoprostol)
Clinoril® (Sulindac)
Daypro® (Oxaprozin)
Feldene® (Piroxicam)
Ibuprofen
Indomethacin
Lodine®, Lodine XL® (Etodolac)
Meclofenamate
Mobic® (Meloxicam)
Nalfon® (Fenoprofen)
Naprosyn® (Naproxen)
Orudis®, Oruvail® (Ketoprofen)
Ponstel® (Mefenamic acid)
Relafen® (Nabumetone)
Tolectin® (Tolmetin)
Toradol® (Ketorolac)
Voltaren® (Diclofenac)

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Oxandrin® Before any code is allowed, there must be an absence of all of the following:
(Oxandrolone)

- a) Hypercalcemia
- b) Nephrosis
- c) Carcinoma of the breast
- d) Carcinoma of the prostate
- e) Pregnancy

110 Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.

111 To compensate for the protein catabolism due to long-term corticosteroid use.

112 Treatment of bone pain due to osteoporosis.

Pacerone® 010 Prescribed or recommended by a cardiologist/internist.
(Amiodarone)

PEG-Intron® 109 Treatment of chronic hepatitis C in patients 18 years of age or older.
(Peginterferon alpha 2b)

Pegasys® 109 Treatment of chronic hepatitis C in patients 18 years of age or older.
(Peginterferon alpha-2a)

Plavix® 136 For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once a day aspirin therapy.
(Clopidogrel bisulfate)

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Pulmozyme® 053 Diagnosis of cystic fibrosis and the patient is **5** years of age or older.
(Deoxyribonuclease)

Rebetron® 008 Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
(Ribavirin/interferon alpha-2b, recombinant)

009 Treatment of chronic hepatitis C in patients with compensated liver disease.

Rebif® 119 Prescribed by, or in consultation with, a neurologist, for the treatment of relapsing multiple sclerosis (MS).
(Interferon beta 1-A)

Reminyl® See criteria for Aricept®.
(Galantamine hydrobromide)

Rena-Vite® 096 Treatment of patients with renal disease.
Rena-Vite RX®
(Folic Acid/Vit B Comp W-C)

ReVia® 067 Diagnosis of past opioid dependency or current alcohol dependency.
(Naltrexone)

Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following:

- a) Acute liver disease; and
- b) Liver failure; and
- c) Pregnancy.

| Drug | Code | Criteria |
|------|------|----------|
|------|------|----------|

Note: A certification form must be on file with the pharmacy before the drug is dispensed. (Sample copy of form attached.)

Rilutek® 089 Confirmed diagnosis of Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease) and the prescription is written by, or in consultation with, a neurologist.
(Riluzole)

Risperdal® 054 All of the following must apply:
(Risperidone)

- a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and
- b) Patient is 6 years of age or older; and
- c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.

(dementia indication deleted)

Ritalin LA® See criteria for Concerta®.

Roferon-A® 030 Diagnosis of hairy cell leukemia in patients **18** years of age or older.
(Interferon alpha-2b recombinant)

032 Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age or older.

080 Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.

109 Treatment of chronic hepatitis C in patients **18** years of age or older.

| Drug | Code | Criteria |
|---|------|--|
| Rythmol® (Propafenone) | 010 | Prescribed or recommended by a cardiologist/internist. |
| Sandostatin® (Octreotide acetate) | 056 | Diagnosis of severe diarrhea and flushing due to metastatic carcinoid tumor. |
| | 057 | Diagnosis of therapeutically unresponsive severe diarrhea due to vasoactive intestinal polypeptide tumor (VIPoma). |
| | 058 | Diagnosis of AIDS with refractory diarrhea. |
| | 098 | Reduction of blood levels of growth hormone and IGF-I in acromegaly patients who have inadequate response or cannot be treated by surgical resection, pituitary irradiation, or bromocriptine mesylate at maximum tolerated doses. |
| Seconal Sodium® (Secobarbital sodium) | 090 | Limited to a one-week supply for pregnant women in the third trimester immediately preceding delivery. |
| Seroquel® (Quetiapine fumarate) | 054 | All of the following must apply: <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis as determined by a qualified mental health professional; and b) Patient is 6 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above. |
| Sonata® (Zaleplon) | | See criteria for Ambien®. |

| Drug | Code | Criteria |
|---|------|--|
| Soriatane® (Acitretin) | 064 | Treatment of severe, recalcitrant psoriasis in patients 16 years of age or older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following: <ul style="list-style-type: none"> a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy. |
| Strattera® (Atomoxetine Hcl) | 007 | All of the following must apply: <ul style="list-style-type: none"> a) Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD); and b) Patient is 6 years of age or older. |
| Suboxone® (Buprenorphine/ Naloxone) | 019 | Before this code is allowed, the patient must meet all of the following criteria. The patient: <ul style="list-style-type: none"> a) Is 16 years of age or older; b) Has a DSM-IV-TR diagnosis of opioid dependence ; c) Is psychiatrically stable or is under the supervision of a mental health specialist; d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, |

| Drug | Code | Criteria |
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and rifampin, unless dosage adjusted appropriately; and
h) Is enrolled in a state-certified chemical dependency treatment program.

Limitations:

- No more than a 14-day supply may be dispensed at a time;
- Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;
- Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and
- Clients may receive up to six months of buprenorphine treatment for detoxification and stabilization.

Note: A Buprenorphine-Suboxone Authorization Form [DSHS 13-720] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:**
<http://www.wa.gov/dshs/dshsforms/forms/eforms.html>

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| Synarel® (Nafarelin acetate) | 059 | Diagnosis of endometriosis amenable to hormonal management in patients 18 years of age or older. Treatment limited to six months. Patient must have an absence of all of the following: a) Pregnancy; and b) Breast-feeding; and c) Hypersensitivity to GnRH. |
| | 060 | Diagnosis of central precocious puberty (CPP). |
| Talacen® (Pentazocine/ acetaminophen) Talwin NX® (Pentazocine) | 091 | Patient must be 12 years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine. |
| Tambocor® (Flecainide acetate) Therevac Plus® 065 (Docusate sodium benzocaine) Therevac SB® (Docusate sodium) | 010 | Prescribed or recommended by a cardiologist/internist. Diagnosis of any of the following and the patient has tried and failed at least 3 other agents/modalities: a) Quadriplegia or paraplegia; b) Severe cerebral palsy; or c) Severe muscular dystrophy. |
| Ticlid® (Ticlopidine) | 066 | Diagnosis of stroke or stroke precursors, or for patients who have had a thrombotic stroke. The patient must be intolerant to aspirin. |
| Tonocard® (Tocainide) | 010 | Prescribed or recommended by a cardiologist/internist. |
| Vancomycin® | 069 | Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole. |

| Drug | Code | Criteria |
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| Vancomycin® IV/Inj. | 103 | Treatment of patients with methacillin resistant staph aureaus infections. |
| Venofer® (Iron sucrose complex) | | See criteria for INFED®. |
| Vioxx® (Rofecoxib) | | Before any code is allowed, the patient must: |
| | | a) Have an absence of a history of ulcer or gastrointestinal bleeding; |
| | | b) Have tried and failed or is intolerant to at least two generic NSAIDs; and |
| | | c) Be 18 years of age or older. |
| | 050 | Diagnosis of rheumatoid arthritis and dose limited to 25mg or less per day. |
| | 051 | Diagnosis of osteoarthritis and dose limited to 12.5 to 25mg per day. |
| | 052 | Diagnosis of acute pain, including primary dysmenorrhea and dose is limited to 50mg or less per day for 5 days. |
| Vitamin ADC Drops | 093 | The child is breast-feeding, and: |
| | | a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and |
| | | b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source. |
| Vitamin B-12 Injection | 075 | For the treatment of vitamin B-12 deficiency (pernicious anemia). |

| Drug | Code | Criteria |
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| Vitamin E | 105 | Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: |
| | | a) Caution is addressed for concurrent anticoagulant treatment; and |
| | | b) Dosage does not exceed 3,000 IU per day. |
| Wellbutrin SR® (Bupropion SR) | 014 | Treatment of depression. |
| Zenapax® (Dacizumab) | 138 | For prophylaxis of acute organ rejection in patients receiving renal transplants when used as part of an immunosuppressive regimen that includes cyclosporine and corticosteroids. |
| Zofran® (Odansetron) | | See criteria for Kytril® |
| Zometa® (Zoledronic acid) | 011 | Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors. |
| Zovirax® Oint (Acyclovir) | | Before any code is allowed, there must be an absence of pregnancy. |
| | 070 | Diagnosis of shingles or immunodeficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®. |
| | 071 | Diagnosis of herpes simplex, types 1 & 2; varicella-2 zoster; or immuno-deficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®. |
| | 072 | Diagnosis of non-life threatening mucocutaneous herpes simplex virus infection or immuno-deficiency, and the patient has a contraindication to, or intolerance for, oral Zovirax®. |

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Zyprexa®
Zyprexa Zydis®
(Olanzapine)

See criteria for Risperdal®.